



**Commonwealth of Massachusetts
Health Care Quality and Cost Council
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Chair

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Patient Safety Committee

Meeting Minutes

Wednesday, April 16, 2008
11:00-12:30pm
One Ashburton Place
21st floor, room 3
Boston, MA

Council Members Present: Beth Capstick (chair), Jim Conway and Katharine London.

Meeting called to order at 11:04am

I. Approval of Minutes of Committee Meeting March 19, 2008

The Committee approved the minutes of its March 19, 2008 Committee Meeting

II. Whole System Mortality Measure – Update

Brian Alexander, Consultant, Division of Health Care Finance and Policy

Brian Alexander, a Consultant with the Division of Health Care Finance and Policy, presented updates on the Whole System Mortality Measure project. Mr. Alexander reported that DHCFP is currently compiling a summary of hospital-wide mortality measures, obtaining input from experts and coordinating with, and drawing upon, other comparable efforts. The Division is also exploring options on how to best evaluate reliability and validity of measures.

Mr. Alexander reviewed the hospital-wide mortality measures that are currently being used in hospitals across the United States, i.e.:

- All Patient Refined Diagnosis related Groups (APR-DRG)
- Hospital Standardized Mortality Ratios (HSMRs)
- University HealthSystem Consortium (UHC)
- Care Science/Premier
- Health Grades
- AHRQ Low-mortality DRGs – not including for now since does not represent hospital-wide experience

Mr. Alexander discussed risk adjustment and reviewed the strengths and weakness of the following measures: All Patient Refined Diagnosis Related Groups (APR-DRG), Hospital Standardized Mortality Ratio (HSMR) and the University Health System consortium (UHC).

The Committee discussed the different methodologies currently being used by hospitals and agreed that it would be beneficial and useful to compare the measures and identify the “best” measure for use on the HCQCC website.

The Division will present updates to members of the Council at the next Committee meeting. (*The presentation file will be posted on the HCQCC website*).

III. Current Patient Safety Activities in Massachusetts

Paula Griswold, *Coalition for the Prevention of Medical Errors*

Paula Griswold from the *Coalition for the Prevention of Medical Errors* presented an update on the *Current Patient Safety Activity Grid* which will help the Council identify gaps and overlaps in patient safety activities across the state. There have been some additional updates to the activity grid since the March 2008 meeting; however, the Coalition is still encouraging and seeking assistance in adding patient safety activities not yet reported.

Ms. Griswold also gave a presentation on the *Infection Prevention Collaborative*. The Coalition reviewed a \$150,000 contract from DPH to organize this Collaborative to support hospitals in reducing infections. The Collaborative engages hospital leadership, and hosts and facilitates educational networking sessions that bring leaders and medical teams together to share best practices for infection prevention.

Ms. Griswold reported on three educational programs offered for hospitals for infection prevention in the Collaborative: *July 2007 Networking : Sharing Best Practices to prevent MRSA Infections* , *November 2007 Workshop on Engaging Front Line Staff in Infection Prevention* at the *BCBSMA Hospital Quality Symposium* , and an *April 2008 program: Improving Hand Hygiene*.

Ms. Griswold’s presentation included a list of the activities currently being operated through the Collaborative that include:

Listserve – 100% acute hospitals and nine non-acute– more than 220 people

Website – posting tools and strategies

Mini Collaborative – Engaging front-line staff in infection prevention (15 hospitals, including non-acute)

Conference Calls (and audio CDs)

Dec 2007 – Engaging front-line staff – 62 participants

Jan 2008 – Engaging front-line staff – 92 participants

Feb 2008 – Preventing VAP – 121 participants

Mar 2008 – Environment cleaning/disinfection – 111 participants

The Collaborative is also operating a *Consumer Education Information Project* that includes:

Collaborating with

- participating hospitals
- IHI
- Betsy Lehman Center
- Partnership for Healthcare Excellence

Messages for general public

- Reduce inappropriate antibiotic use
- Hand hygiene, cough etiquette
- MRSA prevention

Education for patients, families, visitors

- Pre-admission, during hospitalization, post-discharge

IV. Kristin Golden, Department of Public Health (DPH)

Kristin Golden from the Department of Public Health reported that DPH sent a letter to hospitals clarifying the definition of reportable events.

Stancel Riley reported that the Board of Registration in Medicine is working with DPH to develop consistent definitions for Serious Reportable Events.

In discussing hospital acquired infections, Ms. Golden also reported that DPH required hospitals to register by April 1, 2008 with the CDC National Reporting System and to give DPH and the Betsy Lehman Center access to the hospitals on-line reporting to the CDC.

DPH also further required hospitals to begin reporting Hospital Acquired Infections to the CDC by July 1, 2008.

Meeting Adjourned at 12:32pm